



# MFP Transition Screening Form

Participant FName: \_\_\_\_\_ MI: \_\_\_ LName: \_\_\_\_\_

1. Do you want to live somewhere other than this facility?  Yes  No

Screening Type/Date (Check one box) <input type="checkbox"/> Initial F2F Screening _____ (mm/dd/yyyy) <input type="checkbox"/> F2F Re-screening _____ (mm/dd/yyyy) Screener's Name: _____ Screener's Contact: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity: <input type="checkbox"/> Not Hispanic, Latino, Spanish <input type="checkbox"/> Mexican, Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another (Print Origin): _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black, African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other (Print): _____	MFP Target Population (Check one box): <input type="checkbox"/> OA-Older Adult (65+) <input type="checkbox"/> PD-Physical Disability <input type="checkbox"/> TBI-Traumatic Brain Injury <input type="checkbox"/> DD-Developmental Disability	Primary Disability (Check only one): <input type="checkbox"/> D1-Cognitive (TBI, DD, dementia) <input type="checkbox"/> D2-Hearing (deaf/HoH/H loss) <input type="checkbox"/> D3- Mental/SPMI <input type="checkbox"/> D4- Physical (mobility, stamina) <input type="checkbox"/> D5- Vision (Blind/Low Vision) <input type="checkbox"/> D6- N/A <input type="checkbox"/> D7- DNK <input type="checkbox"/> D8- Refused
Date of Initial MFP referral: _____ (mm/dd/yyyy) Date of Waiver Referral: _____ (mm/dd/yyyy)	Referral Source: <input type="checkbox"/> RS1-Inpatient Facility <input type="checkbox"/> RS2-MDSQ <input type="checkbox"/> RS3-Self <input type="checkbox"/> RS4-Family Member <input type="checkbox"/> RS5-CIL, LTCO <input type="checkbox"/> RS6-AAA/ADRC <input type="checkbox"/> RS7-Waiver Case Mgr <input type="checkbox"/> RS8-Personal Care Home <input type="checkbox"/> RS9-Assisted Living Facility <input type="checkbox"/> RS10-Legal Representative <input type="checkbox"/> RS11-Other (specify): _____	Waiver Referral: <input type="checkbox"/> CCSP <input type="checkbox"/> SOURCE <input type="checkbox"/> ICWP <input type="checkbox"/> NOW <input type="checkbox"/> COMP <input type="checkbox"/> Other Waiver (specify): _____ <input type="checkbox"/> No Waiver Referral	Refused/ineligible: <input type="checkbox"/> in NF < 90 days <input type="checkbox"/> no Medicaid <input type="checkbox"/> didn't transition to qualified residence <input type="checkbox"/> didn't cooperate in planning process <input type="checkbox"/> no longer wished to participate <input type="checkbox"/> Other (specify): _____	
Primary Language: <input type="checkbox"/> American Sign Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Korean <input type="checkbox"/> Other (specify): _____		<input type="checkbox"/> Deaf or Hard of Hearing Requires Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: _____		

## Personal Data:

2. First Name: \_\_\_\_\_ MI: \_\_\_ Last Name: \_\_\_\_\_

3. Date of Birth (mm/dd/yyyy) \_\_\_\_\_ SSN: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

4. Medicaid # \_\_\_\_\_ Medicare # \_\_\_\_\_

5. Inpatient Facility Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Facility Street Address: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

**MFP field personnel note:** All data elements on form must be completed. Incomplete forms will be returned. Standards of promptness apply. Send completed form to DCH MFP via FTP.  
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6. Discharge Planner/Contact FName: \_\_\_\_\_ LName : \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

7. Marital Status:  Single  Mar  Div  Widowed  Sep  Other: \_\_\_\_\_  
(if applicable) Spouse Name and address: \_\_\_\_\_  
\_\_\_\_\_

8. Are you a veteran?  Yes  No. Did you serve during wartime?  Yes  No

9. Do you have a guardian?  Yes  No. If yes, list name and contact:  
\_\_\_\_\_

(Screener note: Ask the person who they would like to include in the screening process—family members, friends, etc. If person has a guardian, stop the interview and reschedule the screening when these persons can participate).

## Background Data:

10. What were the reasons you entered this facility? \_\_\_\_\_  
\_\_\_\_\_

11. How long have you lived here at this facility? \_\_\_\_\_ years \_\_\_\_\_ months  
(Screener note: to qualify for MFP, the person must have resided in an inpatient facility for a minimum of 90 consecutive days, short term rehab stays do not count).

(Screener note: At this point in the screening interview, introduce, review and obtain signature on *Authorization for Release of Information and Informed Consent for MFP*).

12. Do you have any family living in this area?  Yes  No  
If yes, list name, phone number and address:  
\_\_\_\_\_  
\_\_\_\_\_

13. Are there family member(s) or friend(s) that would be interested in your move to the community?  Yes  No

14. May we contact these family member(s) or friends(s) to meet with you and us to discuss your move to the community?  Yes  No

If yes, please provide their name(s) and telephone number(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## Housing Section:

15. Where did you live before you came here? \_\_\_\_\_

Screener note: after the person answers, code the response by checking the box below-  
 01-own home,  02-family home,  03-apt/house leased by participant,  04-apt leased/assisted living,  05-group home/PCH,  06-Other (specify) \_\_\_\_\_

16. What Georgia County did you live in before you came here? \_\_\_\_\_

17. Do you want to return to (living situation in Q15)?  Yes  No

18. If yes, what prevents you from returning to (living situation in Q15)? \_\_\_\_\_

19. Do you have a home to move back into?  Yes  No

If yes, the address (street, city, zip, county) of your home: \_\_\_\_\_

20. (If applicable) Does anyone live in your home?  Yes  No

If yes, what are their names and relationship to you? \_\_\_\_\_

(Screener note: discuss MFP qualified housing. Tell the candidate that while MFP will assist the person to locate qualified housing, the MFP project does not cover the cost of rent or utilities and that to participate in MFP, the person must enter qualified housing).

21. Which type of qualified housing are you interested in and why? \_\_\_\_\_

Screener note: after the person answers, code the response by checking the box below-  
 01-own home,  02-family home,  03-apt/house leased by participant,  04-apt leased/assisted living,  05-group home/PCH,  06-Other (specify) \_\_\_\_\_

22. What Georgia County do you prefer to live in? \_\_\_\_\_

23. Do you have someone you want to live with?  Yes  No

If yes, list contact information \_\_\_\_\_

## Waiver Service History:

24. Did you receive services in your home before coming here?  Yes  No

If yes, what services: \_\_\_\_\_

25. Are you currently on a waiver waiting list for home & community based services?  Yes  No If so, which waiver? \_\_\_\_\_

26. Do you have a letter or contact information from the waiver?  Yes  No

If yes, where is the letter or contact information and who can bring these to you? \_\_\_\_\_



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## Financial Data:

(Screener note: Review facility records to obtain or confirm this information. The signed informed consent will allow you to obtain and review inpatient facility records).

### 27. Income and Resources:

SOURCE	MONTHLY AMOUNT	PAYEE
<input type="checkbox"/> SSDI <input type="checkbox"/> SSI <input type="checkbox"/> SS Retirement		
PENSION BENEFITS		
TRUST PROCEEDS		
INHERITANCE		
VETERAN'S COMPENSATION		
CASH		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
SAVINGS ACCOUNT (DESIGNATED BURIAL)		
CEMETERY PLOT		
RAILROAD RETIREMENT		
LIFE INSURANCE		
CERTIFICATE OF DEPOSIT		
OTHER (SPECIFY)		



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28. Who is paying for your stay here? \_\_\_\_\_

29. Are you Medicaid eligible, but subject to transfer of asset penalty?  
 Yes  No  DNK (Do Not Know) (Screener note: check facility records)

### Health Care Needs:

30. How would you describe your primary disability or limitation? \_\_\_\_\_

Screener note: After the person provides a primary disability, confirm that the response fits into one of the following categories and check the box:  D1- Cognitive (TBI/DD, dementia),  D2- Hearing (Deaf/HoH/Hearing loss),  D3- Mental Health/SPMI,  D4- Physical (Mobility/Dexterity/Stamina),  D5- Vision (Blind/Low Vision),  D6- Not Applicable,  D7- DNK,  D8- Refused

31. Who is your doctor here at this facility? \_\_\_\_\_

32. Do you have a primary care doctor or clinic in the community?  Yes  No

If yes, list contact information? \_\_\_\_\_

33. Do you need help taking your daily medications?  Yes  No

Describe assistance needed: \_\_\_\_\_

34. What specialized medical equipment (DME) and assistive technology devices do you use?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

35. Which equipment or devices need to be obtained because you don't own them or they need to be replaced?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## 36. Functional Needs -

See KEY below for instructions to complete:

<b>Function:</b> Ask, "Do you need help with (activities below)? (observe person doing activity when possible)"	<b>Impairment:</b> If assistance needed, check yes	<b>Unmet Need:</b> Ask: Do you have an <b>unmet need</b> for help with (activities) _____ in the community?	<b>Comments:</b> Identify sources of assistance in the community, resources, assistive technology, DME used. Describe special needs and circumstances that should be taken into account when developing a plan for services and supports
1. Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Grooming	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Transferring	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Continence	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Managing Money	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Telephoning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Preparing Meals	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Housework	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Outside Home	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Routine Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Special Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Being Alone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>KEY</b> Assistance Needed in the Community Ask: <b>Do you need help with (activities listed above #1-15)?</b> When appropriate, observe the person in the activity.		<b>Unmet Need for Care</b> – when person returns to the community Ask: <b>When you return to the community, do you have an unmet need for someone to help you with _____ (activities listed above #1-15)?</b> If participant has assistance of family/friend/caregiver or assistive device, the answer would be <b>NO</b> . If participant <b>has no assistance</b> , the answer would be <b>YES (there is an unmet need for care)</b> . Note observations.	

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37. Home Community Based Service (HCBS) referral to:

- CCSP (AAA/Gateway)
- SOURCE (SOURCE Case Management)
- Independent Care Waiver (ICWP) (GMCF)
- NOW/COMP Waiver (DBHDD-DDD/MFP Office)
- No Waiver Referral Made (specify reason) \_\_\_\_\_
- State Plan Services (list) \_\_\_\_\_
- Non-Medicaid Services (specify) \_\_\_\_\_

38. Date of referral to HCBS waiver \_\_\_\_\_ (mm/dd/yyyy).

39. Date HCBS waiver application submitted: \_\_\_\_\_ (mm/dd/yyyy)

40. Date HCBS waiver assessment completed: \_\_\_\_\_ (mm/dd/yyyy)

41. I DO NOT wish to participate in MFP:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## Document Checklist:

(Screener note: attach the following documents. Send these copies and copy of completed MFP Transition Screening Form with referral for HCBS waiver).

- Copy of MFP Informed Consent for Participation
- Copy of Authorization for Use or Disclosure of Health Information
- Copy of Medication Administration Record (MAR) or list of current medications
- Copy of State Medicaid Card
- Copy of Medicare Card
- Copy of Social Security Card
- Copy of Legal documents that cover guardianship (on file at institution)
- Copy of Documents that cover Power of Attorney (on file at institution)
- Nursing Home Face-Sheet
- Other (Specify) \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_

## MFP Field Personal Contact Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**MFP field personnel note:** the MFP Transition Screening Form must be submitted even when the person being screened refuses participation or is found to be ineligible. If the person refuses participation, be sure Question 41 is signed.